



2011

City of Memphis ENROLLMENT / ACTIVE CHANGE FORM

Note: Only complete if you wish to change plans, add or delete dependents or currently do not have City health coverage and elect to enroll in a plan.

EMPLOYEE INFORMATION				APPLYING FOR (COMPLETE ALL THAT APPLIES)			EMPLOYER USE ONLY	
Employee Name (Last Name, First Name, Middle Initial)		List PCP ID Number		<input type="checkbox"/> PRE TAX	<input type="checkbox"/> POST TAX		EFFECTIVE DATE EMPLOYEE / /	
Social Security Number — —	Sex (M or F)	Date of Birth – MM/DD/YY		<input type="checkbox"/> CITY OF MEMPHIS BASIC			EFFECTIVE DATE DEPENDENT(S) / /	
Street Address				<input type="checkbox"/> CITY OF MEMPHIS PREMIER			TERMINATION DATE / /	
				<input type="checkbox"/> ENROLL <input type="checkbox"/> DELETE <input type="checkbox"/> CANCEL			DIVISION CODE	
City		State		Zip		<input type="checkbox"/> Waive Coverage		
Daytime Phone Number ()		Evening Phone Number ()		YOUR PLAN WILL COVER			ENTERED BY	
Division		E-Mail Address		<input type="checkbox"/> FAMILY <input type="checkbox"/> SINGLE			HIRE DATE: / /	
							EMPLOYMENT STATUS ___ ACTIVE ___ COBRA ___ NEMP	

List all dependents you wish to ADD TO YOUR COVERAGE or DELETE FROM YOUR COVERAGE or UPDATE SOCIAL SECURITY NUMBER on your coverage

Last Name	First Name	Initial	Social Security Number	Date of Birth (MM/DD/YY)	Sex (M or F)	Full Time Student (YES / NO)	For Premier ONLY (List PCP ID Number)
Spouse							
Dependent							
Dependent							
Dependent							
Dependent							

If you or your dependents are covered by other group insurance, please fill out the following information:

Name of Person covered by other insurance		Social Security Number 		Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D		Effective Date / /	
Name of Company this Person works for		Group No.		Medicare HICN: Name: Relationship: Comments:					
Name of other Insurance Company		Effective Date:							
List dependents Covered:									

By signing below, I certify that: the information provided above is true and correct. I accept the plan rules as set forth by the City of Memphis; and I authorize payroll deduction for the plan above.

Form must be completed and signed by City employee to be accepted		NOTARY SIGNATURE	NOTARY EXPIRATION DATE
Signature	Date		

FLEXIBLE BENEFITS PRE-TAX PROGRAM

You may choose to have your benefit deductions classified as tax-exempt. This allows your contributions to the benefits plans to be exempt from federal withholding tax and increase your take home pay. Included in these benefits deductions are Health Plans, Life Insurance (up to \$50,000) and Dental Plans.

- Your decision remains in effect until our annual open enrollment period, unless there has been a change in family status. If a change in family status occurs, you must contact the Benefits Office and submit all necessary paperwork within 60 days of the status change to change your coverage.
- If you want your premiums to be pre-tax, CHECK THE PRE-TAX on the front of the application. If no box is checked, you will be deemed to have elected pre-tax premiums.